

especially the caustics, and the frequently unbearable pain within the growth, had undermined her health. When I saw her, a little over one year ago, there was a solid sessile tumor, the size of about a silver quarter, extending from the region below the tragus into the cheek. The lobule and lower posterior half of the auricle were gone, and from the edge of the rest of the auricle a dense and unyielding cicatricial tissue extended into the integument below and behind the ear. The tumor was flat, about one-sixteenth of an inch elevated above the surrounding skin, ordinarily pale, and not sensitive to the touch. At the time of menstruation it was usually congested, and slightly more elevated, and caused, especially at such times, but occasionally also during the intervening period, the most intense and lancinating pain.

The tumor was removed by an elliptical incision in healthy tissues, care being taken to lift it with a portion of the subcutaneous adipose tissue from its location. After severing, by deep incisions, some of the cicatricial bands behind and below the tumor, I was enabled to close the wound by sutures. Primary union. There remained a thin linear scar, the pain disappeared within a few days, and there have been no signs of recurrence as yet, one year after the operation. On former occasions the tumor showed signs of reappearance within six months.

The microscopic examination, made by Prof. Kramer of the Cincinnati College of Medicine and Surgery, showed the removed tumor to be a true keloid. The epidermis was atrophied, and hairs, hair-follicles, and glands were entirely absent. The Malpighian layer was distinctly preserved, but there were only scanty traces of papillæ. Immediately below them, and arranged in layers parallel to the surface there was a dense mass of fibrous tissue in which here and there blood vessels, some compressed, appeared. Among the bundles of fibrous tissue, occasional elastic fibers were noticed, and also, frequently, groups of spindle cells. Below this was a looser connective tissue, with many cellular elements, and a gradual merging into adipose tissue. It is too early as yet to say whether the last removal will not be followed by a recurrence.

It is true that most authors insist upon the possibility, and even probability of a return of these growths after operations. But no treatment has as yet been devised that will actually give better results; while Erichsen,¹⁴ though admitting their liability to return after excision, calls this their only treatment. And in this case, the almost intolerable sufferings of the patient, whose best years had been sacrificed in the battle with this baneful disfiguration, compelled me to do something that gave her at least a slight chance of a permanent cure.

These cases do not demonstrate anything new, but having occurred under my own observation lead me to believe that they are still more frequent than we usually think. And while in most cases no serious consequences result from the folly of piercing the ear lobes, yet there occur, from time to time, cases where a life is at stake, or where the enjoyment of life is seriously interfered with. It is time that this relic of barbarism ought to be relegated where it belongs,—to the by-gone follies of superstition and fashion. And the day is, I hope, not far distant, when it will be considered an evidence of brutality to have a tender and unprotected child subjected to such an unnecessary and mutilating procedure.

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¹⁴ The Science and Art of Surgery, Vol. II, p. 314.

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THERAPEUTIC INDICATIONS OF RHEUMATIC PATHOLOGY.

BY THOS. O. SUMMERS, M.A., M.D., F.Sc.S. LOND., D.D.S.
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Notwithstanding the fact that the literature of medicine is teeming with disquisitions and discussions upon the subject of rheumatism, there appears to be nothing within the whole range of pathologic investigation upon which the profession to-day stands so greatly at variance as upon this, perhaps the most cosmopolitan "of all the ills that flesh is heir to." Theory after theory has been propounded and exploded; remedy after remedy proposed and rejected until the whole "Pharmacopœia" has been exhausted, and the shelves of the apothecary crowded to overflowing with charlatan nostrums and proprietary preparations sufficient to float a fleet, in the apparently vain effort to find relief from this universal and intractable malady.

While, therefore, I do not propose to add anything to the fund of actual information on the pathologic principles upon which rheumatism is founded, I do propose to bring out and apply those principles in such a manner as to establish the true line of therapeutic action in its treatment.

It is very often the case that, in those diseases which are most common, the treatment is so generally ineffectual on account of the fact that our therapeutic leaders overlook the very simple pathologic principles which govern them, in their vain search for some occult factor in the problem which in reality does not exist. Most undoubtedly is this true in regard to the disease under consideration, as I hope I shall be able to demonstrate.

A great deal of the nebulosity which hangs about the subject of rheumatism arises from its peculiar relation to those specific disorders with which it has been classified by pathologists as *cousin-german*—such as syphilis, scrofula, tuberculosis *et id omne genus*—known to ultimate pathologic analysis as *leucocythemie* in origin.

I do not know that I could introduce this discussion in a more striking manner than by the relation of a little incident which occurred to me some eighteen years ago, while an associate editor of the *Nashville Journal of Medicine and Surgery*. Being the youngest of the editorial staff, the "make-up" of the *Journal* was left to my supervision. Our old foreman, "Father" Brown, as we familiarly called him, was a regular copy-fiend. He was never satisfied without a lot of extra "live matter" from which to select in "making up." One day I entered the composing room and was greeted by the old man with a regular tirade, on account of not having just the amount of matter necessary to fill out a little space, and he wanted me to prepare it at once. I snatched up some galley proof paper and began to write just what came first into my head. I had just left my microscope, upon the stage of which was resting some preparations of corpuscles from pus, from rheumatism and from normal blood which I had been comparing. So in the little "take" which I handed over to the old foreman I simply announced the conclusion at which I had arrived only a few moments before, that the cause of pain in rheumatism was undoubtedly due to the migration of the white blood corpuscle which, continuing to live out-

side the vessels, not only appropriated nutritious material to its own use at the expense of the normal tissues of the body, but became bloated with riotous living, swelled up inordinately and impinged inconveniently upon space belonging to the delicate nerve filaments distributed to contiguous structures. It was, indeed, a new conclusion to me, but I was no less surprised than pleased some time thereafter to find the little item copied by the *London Lancet* with due credit, and with a tacit, but yet apparent indorsement, and from this it went the whole rounds of the foreign and American medical press.

I may say that *I have since then found no reason to contradict or modify the conclusion then so casually and cursorily made.* On the contrary, starting with this, I carried my investigation and my reasoning farther in the same direction and was astonished to find what a wonderful field of fact was opened up before me. I saw at a glance the many and wonderful pathologic conditions capable of being brought about by this migrated corpuscle—this "*Wandering Jew*" of the organism. Protean in relation as in form, and as a vital physiologic unit capable of independent life, a most dangerous element in all pathology, involving assimilation of pabulum, and nutrition of structure.

At the risk of becoming trite in the eyes of those who are continually occupied with pathologic investigations and are familiar with pathologic technology, I shall review in a cursory manner the structural morphology and the functional relationship of this *white blood corpuscle* or *leucocyte*, from its first active appearance in the blood, directing and controlling as it were the distribution of nutrition from within the prison walls of the blood vessels, to its wanton was-sail while carousing over the spoils of the organism after escape from its forced vascular confinement. In this connection it may not be uninteresting, even to the most of the JOURNAL readers accustomed to the microscopic views of the amoeboid movement, to observe the relationship which exists between the corpuscle, as it floats in the plasma, and the corpuscle freed from its physiologic restraint. Unlike its red companion it has a vitality of its own and depends not for its existence upon a fixed and necessary environment. Take the red corpuscle from its home in the plasma of the blood in which it purls along content with its surroundings, and doing quietly and submissively the behest of the organism in carrying and delivering its freight of vivifying air. Not only is it content with its environment, but it can exist under no other conditions, and the moment it is removed from its normal surroundings it sinks at once into retrograde metamorphosis and final death. Not so with the white corpuscle. From the first moment of its physiologic existence it engages in an endless struggle for freedom. In its course through the organism it tries every osmotic crevice in the walls of the blood vessels, taking every shape that it may deem better adapted to its escape from prison. On its exit from the "pent-up Utica" of its tubular jail, it sets up housekeeping on its own account, and its extravascular or pathologic life is far more active than its physiologic existence, for it really seems to begin life in earnest when freed from the restraint of physiologic law. So strikingly is this manifested that pathologists have often been led to wonder why an element so necessary to physiologic integrity should show its greatest activity under pathologic conditions—a question which the limits

of this paper do not permit me to discuss in this connection.

There is, however, a point which requires our attention just here, and that is that a low nutritive condition of the blood is peculiarly favorable to the migration of the white corpuscle. Where the plasma is thick and charged with nutritive elements there is little room left in the osmotic spaces for the escape of the corpuscle, and besides it is kept in a state of constant activity in handling the nutritive freight of the organism, if we may be allowed to carry out the metaphor, to find time to look for avenues of escape, for in the physical as well as in the moral world,

"Satan finds some mischief still
For idle hands to do,"

and the greater number of pathologic conditions arise from inactivity of function, rather than from lesion of structure.

This relation of the poverty of the blood to the increased migratory tendency of the white corpuscle will suggest at once to the thinking mind the therapeutic indication in the pathologic premises. It will be clear that anything that favors osmosis, that excites absorption, thus occupying the avenues of escape with nutritive material, will not only arrest migration but prevent the preying of the corpuscles which have already escaped, upon surrounding structures. Foremost among such agents stands iodid of potassium, which seems to have a more marked effect, both in regulating the physiologic activity of the white corpuscle and in protecting the tissues from its ravages when once it has escaped and become ensconced among them. It is, then, not in the least surprising to find that in all those diseases which have been referred to as *cousin-german* to rheumatism, marked as they are by an increase of the white blood corpuscles in proportion to the red, iodid of potassium has even empirically become a standard remedy. Anything, too, which excites secretion, will also tend to check this migration and neutralize the pathologic effect of the corpuscle. And above all other therapeutic agents which have been proved effectual in this relation calomel rears its head; whatever malediction and abuse have been hurled at this grand old remedy, like Banquo's ghost, "it will not down," and a sad day it will be for medicine when, through the fashionable tendencies of the times, the profession becomes too cowardly to use a remedy that the experience of ages has tested and indorsed.

Upon the basis of what has been said, therefore, I offer my own method of treatment in rheumatism, both chronic and acute, and though the remedies may seem old fashioned, the proportion used and the manner of their combination prove their practical value and, substantiated as they are by the pathologic indications, I always administer them with confidence.

At night, before retiring, I order a hot mustard foot bath and the following prescription:

R. Pulv. Dov gr. xv.
Hyd. chlor. mit gr. x.
M. et. ft. capsul. No. ij.
S. Take both before retiring.

I always direct these capsules to be taken with a solution of bicarbonate of soda 3j, to water 3vj.

Go at once to bed and *stay* there. In the morning, if there is no action on the bowels, give a bottle of solution of citrate magnesia freshly prepared. I then order the following:

R. Potass. iodid	3ss.
Vini colch. rad	aa
Fl. ext. sarsae	3ij.
Tinct. cinchon. comp	

Mix.

S. Dessertspoonful in half a glass of water one hour after each meal.

Sometimes this dose must be varied on account of idiosyncrasy—this the physician must decide in each particular case.

This treatment usually gives relief and is founded upon a true and solid pathology.

OBSTRUCTION OF THE BOWELS.

Read before the Medical and Chirurgical Faculty of Medicine at the Semi-Annual Meeting held at Annapolis, Nov. 23, 1893.

BY EDWARD ANDERSON, M.D.

ROCKVILLE, MD.

I have had a good many cases of this trouble, as all of you who have been in practice for a number of years must have had. On being summoned to the bedside of a patient suffering from obstruction of the bowels there are three questions we should ask: What has the patient been eating? What doing? And whether he or she is of a constipated habit?

Although I have never seen complete obstruction caused by scybala, I have seen it sufficiently so to have caused death had not timely remedies been employed. I will mention a case in point later on.

I have always been able after a few hours' attendance to discriminate between those cases which required surgical interference and those which did not. If complete obstruction occurs suddenly, accompanied by pain sufficiently intense to require the administration of large doses of opium oft repeated, enemas having failed, surgical aid should at once be procured; but if the pain is not intense and we find that hard substances upon which the intestinal juices are unable to act have been swallowed, we can afford to wait, and try other means. Any smooth substance small enough to pass through the esophagus, will be sufficiently so to pass through the intestinal canal, and any number of small bodies collected together in the bowel can be dislodged without resorting to laparotomy. If we know that a large solid substance has been swallowed the best plan to pursue is to allow no purgatives to be given, and to keep the patient as much as possible on solid food until it passes. Large enemata should first be employed in every case of obstruction, particularly so when we have reason to believe that masses of small bodies cause the difficulty; and in suitable cases small doses of calomel repeated at short intervals should be used at the same time. If we can not do for our patients the very best that can be done, we ought to seek the aid of some one who can. This has always been my motto, but our best endeavors are sometimes thwarted, as the two following cases will show: on August 25, 1885, I was called to see a mulatto woman in good circumstances, about 45 years old who the messenger said was suffering from severe cramps. I found her with intense pain in the umbilical region, severe enough to require the hypodermic injection of a fourth grain of morphia every four hours. I threw a large amount of warm water into the bowel which removed some very hard fecal matter, but after that nothing could be brought away; even milk came out of the bowel as white as when thrown in. I told the family at once that an operation would be necessary; this was unwelcome

news as such news always is, especially to the ignorant, and of course the family wanted a consultation. On the second day a consultant was called in who threw out the hope that the recovery might take place without an operation; he proposed that we should give 2 grains of calomel every four hours in addition to the hypodermic of morphia and the rectal injection of milk with which I was sustaining her. Not being able to persuade the husband and children to call in a surgeon, I abandoned the case on the fourth day. I understood from those who were present that the treatment that I inaugurated was kept up until the patient's death, which occurred on the eighteenth day. Although vomiting was incessant from the beginning, it did not become stercoraceous until near the close of life. This woman's alarming symptoms came on immediately after drawing water from a well with a rope, hand over hand, without even a wheel to assist her. What condition the bowels were in I do not know, as no autopsy was held.

A little over two years ago I was called to see a negro woman about 50 years of age who was suffering from intolerable pain in the umbilical region, accompanied by incessant vomiting, which became stercoraceous on the first day. I gave her a hypodermic of one-fourth of a grain of morphia every four hours, and at the same time threw large quantities of warm water into the bowel with the effect of producing one action only, without checking the vomiting in the least. A half gallon of water that I injected was retained until the next day.

When obstruction of the bowel takes place, peristaltic action is lessened, even below the obstruction which favors rectal alimentation. I tried to procure the services of a surgeon in this case but failed to do so. On the third day I succeeded in obtaining the services of a gynecologist, but after he came I could not prevail upon him to open the abdomen, though laparotomy was of almost daily occurrence with him; I had seen him perform supra-vaginal hysterectomy for a large fibroid and do it as skilfully as any one could, yet he hesitated where the bowel was concerned, and told me to go on with my treatment until the next day, when he would come again and operate, if no change for the better had taken place. When he came again she was too weak to be operated upon, it being the fourth day of her illness, and she died at noon that day. Had I known that I could not have this woman operated upon I would have opened her abdomen myself, though I had never performed laparotomy. On opening the abdomen after death, a stone was seen just below the umbilicus, occupying the most constricted part of the ileum and almost as plainly visible through the transparent bowel as it is in my open hand. The first case of obstruction I was ever called to attend was that of a child 10 years old, the daughter of a farmer. The parents were intelligent people and had diagnosed the case properly before I arrived. They said the child had been eating cherries and they supposed had swallowed the stones, which had collected in the bowel. Three tablespoonfuls of castor oil had been given without effect. I gave a teaspoonful of paregoric to relieve the pain and used the syringe every hour during the night, with the result of bringing away a half pint of cherry stones and completely relieving the child.

An old lady, a patient whose bowels had been obstructed for a week and who could not stand the use of enemas was put upon one-sixth of a grain of calomel